The Commonwealth of Massachusetts
Motor Vehicle Insurance - Merit Rating Board
P.O. Box 55889, Boston, Massachusetts 02205-5889
(617)267-3636 Fax (617)351-9660

MARY ANN MULHALL
DIRECTOR

TO: Massachusetts Merit Rating Liaisons

FROM: Mary Ann Mulhall, Director

DATE: April 2, 2008

RE: Revised Surcharge Notice Form

NOTICE NO: 0029

I am enclosing a correction to the Surcharge Notice Form distributed with Notice No: 0028. The word "to" has been added to (E) in the Surcharge Appeal Instructions "(E) The Division of Insurance will notify you as to the date, time and location of your hearing". Please ensure that the attached is distributed to the appropriate personnel.

Notice No: 0029 can be accessed and downloaded from Information for Massachusetts Auto Insurers at our website www.state.ma.us/mrb.

Enclosure
Appendix S: Surcharge Notice Form

Appendix S
SURCHARGE NOTICE FORM

SURCHARGE NOTICE

The (1) _____ (2) _____) Insurance Company hereby notifies the OPERATOR named below that a surcharge may be imposed as required by M.G.L. c. 175 § 113B, as a determination has been made that the OPERATOR is more than 50% at fault for the accident described herein.

This surcharge may result in an increase in premium when an insurance policy is next renewed for any vehicle on which the OPERATOR is listed.

OPERATOR INFORMATION

Name Address City, State Zip	(3)				
Date of Birth	(4)	Driver's License No.	(5)	State Code	(6)

♦ If any of the above operator information is incorrect, do not appeal . Contact your insurance company to make the appropriate corrections.

FOLD FOLD

ACCIDENT INFORMATION

Accident Date	Surcharge Notice Date	Location Code	Policy No.	Claim No.
(7)	(8)	(9)	(10)	(11)

Standard of Fault Code (12) Explanation: (13)

INSURANCE AGENT		POLICYHOLDER (if different than the OPERATOR)		
Name Address City, State Zip	(14)	Name Address City, State Zip	(15)	
		Date of Birth	Driver's License No.	State Code
		(16)	(17)	(18)

SURCHARGE APPEAL INSTRUCTIONS

FOLD FOLD

IF YOU BELIEVE YOU WERE NOT MORE THAN 50% AT FAULT IN THIS ACCIDENT AND WISH TO APPEAL TO THE MASSACHUSETTS DIVISION OF INSURANCE, YOU SHOULD:

(A) Complete the Surcharge Appeal Form on the reverse side of this notice.

(B) Send a check or money order for $50.00 payable to the Commonwealth of Massachusetts. This filing fee is non-refundable. File only one appeal per accident. The Division of Insurance does not accept cash.

(C) Return this completed form with the filing fee by mail to:
DIVISION OF INSURANCE
P.O. BOX 370009
BOSTON, MA 02241-0709

(D) A request for appeal must be submitted and received WITHIN 30 DAYS of the Surcharge Notice Date.

(E) The Division of Insurance will notify you as to the date, time, and location of your hearing.

♦ Filing a surcharge appeal does not prevent the application of the surcharge to the premium. If the surcharge is billed, it MUST be paid. If it is later reversed, your premium will be adjusted, and the amount paid will be refunded or credited by the Insurance Company.

If the operator's mailing address is different than the address shown above, please indicate corrections here →

NAME _____

ADDRESS _____

CITY, STATE ZIP _____